



Lord Selkirk School Division
 Student Services Centre

Student Perspective Form

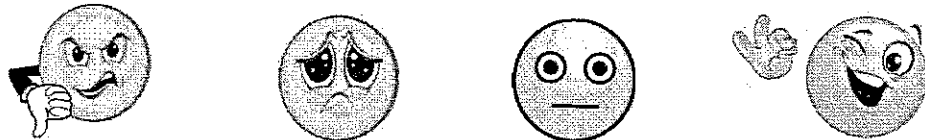
Name:

Date:

Check In Time:

How were you feeling before you use the Multisensory Room?

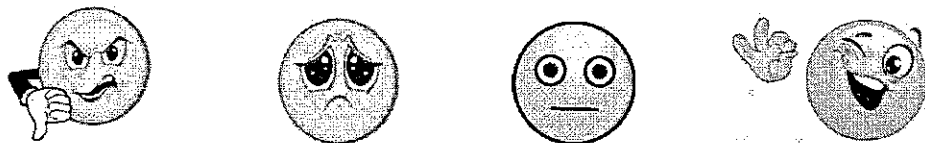
1 2 3 4 5 6 7 8 9 10



Check Out Time:

How are you feeling after you used the Multisensory Room?

1 2 3 4 5 6 7 8 9 10



Items used while in the room:

Weighted modality (describe):	Lotion
Aromatherapy	Music
Stress balls/Fidgets	Art Supplies
Bubble Tube	Therapy Ball
Image Projector	Lava Lamp
Plush/stuffed toys	Disco Ball
Alternative seating (describe):	Others (describe):



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Supervisor Perspective Form

Please hand into resource teacher or classroom teacher upon completion.

Supervisor Name:

Student Name:

Date:

Check In Time:

Please rate the student's level of escalation before use of the Multisensory Room:

1 2 3 4 5 6 7 8 9 10

(highly escalated)

(regulated/content)

Check Out Time:

Please rate the student's level of escalation after use of the Multisensory Room:

1 2 3 4 5 6 7 8 9 10

(highly escalated)

(regulated/content)

Items used while in the room:

Weighted modality (describe):	Lotion
Aromatherapy	Music
Stress balls/Fidgets	Art Supplies
Bubble Tube	Therapy Ball
Image Projector	Lava Lamp
Plush/stuffed toys	Disco Ball
Alternative seating (describe):	Others (describe):

Please include comments on the individual's use of the room and any suggestions to make the space more effective:

What items did the student use that most successfully helped the individual self-regulate?



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Student Perspective on Weighted Modality Form

Name:

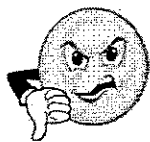
Date:

Weighted item used:

Check In Time:

How were you feeling before you use the weighted tool?

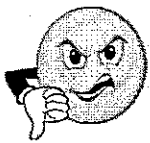
1 2 3 4 5 6 7 8 9 10



Check Out Time:

How are you feeling after you used the weighted tool?

1 2 3 4 5 6 7 8 9 10





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Supervisor Perspective on Weighted Modality Form

Please hand into resource teacher or classroom teacher upon completion.

Supervisor Name:

Student Name:

Date:

Weighted Modality Used:

Check In Time:

Please rate the student's level of escalation before use of the weighted modality:

1 2 3 4 5 6 7 8 9 10

(highly escalated)

(regulated/content)

Check Out Time:

Please rate the student's level of escalation after use of the weighted modality:

1 2 3 4 5 6 7 8 9 10

(highly escalated)

(regulated/content)

Please include comments on the individual's response to and use of the weighted item:



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Student Perspective on Deep Pressure Form

Name:

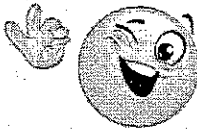
Date:

Activity:

Check In Time:

How were you feeling before you use completed the activity?

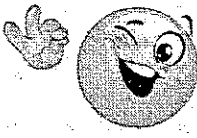
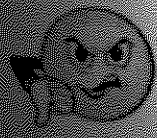
1 2 3 4 5 6 7 8 9 10



Check Out Time:

How are you feeling after you used the activity?

1 2 3 4 5 6 7 8 9 10





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Supervisor Perspective on Deep Pressure Form

Please hand into resource teacher or classroom teacher upon completion.

Supervisor Name:

Student Name:

Date:

Deep Pressure Technique Used:

Check In Time:

Please rate the student's level of escalation before use of the technique:

1 2 3 4 5 6 7 8 9 10

(highly escalated)

(regulated/content)

Check Out Time:

Please rate the student's level of escalation after use of the technique:

1 2 3 4 5 6 7 8 9 10

(highly escalated)

(regulated/content)

Please include comments on the individual's response to and use of the technique:



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Miscellaneous Sensory Tools Tracking Sheet

ITEM/ACTIVITY	RESPONSE (circle)
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
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	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting
	Calming / Alerting



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Multisensory Room Log Sheet

Date	Student Name	Check In Time	Check Out Time	Supervisor Initial